PROVIDER AGREEMENT WITH THE TEXAS DEPARTMENT OF HEALTH
FOR PARTICIPATION IN THE
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM

(Legal Name of Provider)

("Doing Business As" (DBA) Name, if applicable)

(Address) (City, State) (Zip Code)

(Medicaid Provider #) (Internal Local # - assigned by CSHCN)

(Texas Comptroller Vendor ID # - if already assigned)

The provider agrees, in accordance with the state laws, rules and regulations pertaining to the Texas Department of Health (TDH), CSHCN Program, and as a condition for participation in this program, to the terms and conditions set forth below.

1. To maintain and retain for a period of five (5) years from the date of service, or until audit and all audit exceptions are resolved, whichever period is longer, such records as are necessary to fully disclose the extent of the services provided to the clients receiving assistance under the CSHCN Program and the amount claimed for each of such services. If litigation is involved, the records must be retained until litigation is ended or for five years as cited above, whichever is longer.

2. To provide unconditionally, upon request, free copies of and access to all records pertaining to the services for which claims are submitted to the CSHCN Program to representatives designated by the TDH.

3. To accept CSHCN program payment as payment in full for services. Provider may collect allowable insurance or health maintenance organization co-payments in accordance with those plan provisions.

4. To accept payments established by the Texas Medicaid Program as payment in full for Medicaid covered services for those clients who are assisted by this resource.

5. To utilize CSHCN as a resource for payment when clients are eligible for program assistance.

6. The CSHCN program is the payer of last resort, and CSHCN program providers must agree to utilize all other benefits available to the client, including Medicaid or Medicaid waiver programs, Children's Health Insurance Program (CHIP), or Medicare, prior to requesting

payment from the CSHCN program.

7. To not bill the client/family for the cost of any charges not paid for by CSHCN because an authorization was not requested or a claim was not submitted for payment of services within the appropriate submission deadline.

8. To not charge the client/family any pre-admission or pretreatment charges or deposits if services are reimbursable by CSHCN.

9. To refund the client/family any pre-admission or pretreatment charges when services are authorized and collection occurred prior to program application and eligibility determination.

10. To request authorization for services from CSHCN for all services requiring "prior" authorization "before" the date of service.

11. To request authorization for services from CSHCN for all services requiring authorization before the date of service or up to 90 days after the date of service.

12. That claims submitted by me or on my behalf for payment by the CSHCN Program shall be for services or items actually provided by me or under my personal supervision to the eligible recipient identified as the client for which I am entitled to payment. I understand that payment and satisfaction of such claims will be from federal and/or state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws. Fraud is a felony, and is punishable by a fine of not more than $25,000 or imprisonment for not more than five (5) years, or both.

13. To refund to CSHCN any overpayment, duplicate payment, or erroneous payment to which entitlement is not authorized under CSHCN rules and regulations.

14. To comply with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), Sections 504 of the Rehabilitation Act of 1973 (Public Law 93-112) , The Americans with Disabilities Act of 1990 (Public Law 101-336), and all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. In addition, the provider agrees to comply with Title 40, Chapter 73, of the Texas Administrative Code. These provide in part that no persons in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion be excluded from participation in, or denied, any aid, care, service or other benefits provided by federal and/or state funding, or otherwise be subjected to discrimination. To comply with Texas Health and Safety Code Section 85.113 (relating to workplace and confidentiality guidelines regarding AIDS and HIV).

15. To not discriminate against the individual on the basis the person is a CSHCN recipient by means of pricing differentials or other means of discriminatory treatment.

16. To provide language assistance that may be required for effective communication with CSHCN recipients who demonstrate limited English proficiency (LEP) to insure they have equal access to CSHCN services.

17. To provide services to CSHCN recipients in the same manner and to the same degree and quality that these services are provided to the general public.

18. To accept responsibility for informing and insuring that those acting as my agents understand and follow CSHCN rules and regulations.

19. To comply with all requirements of CSHCN regulations, rules, standards, and guidelines published by CSHCN or its designee.

20. To maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

21. To promptly report change of address and/or change in status, including but not limited to change in name, loss of license, change in certification status, or change in Medicaid provider status.

22. To maintain provider enrollment and participation in the Texas Medicaid Program as a condition to participate in CSHCN. Should Texas Medicaid status be terminated, participation in CSHCN may be terminated effective the date of Medicaid termination.

23. That this agreement may be terminated by either party upon thirty (30) days notice to the other party, except that termination may be earlier for submitting false or fraudulent claims, failing to provide and maintain quality services or medically acceptable standards, failure to comply with the provider agreement signed at the time of application or renewal for CSHCN program participation, dis-enrollment as a Medicaid provider or violation of the standards of CSHCN rules and regulations or parts thereof. Provider specifically agrees that Paragraphs 1,2, and 20 of this Agreement concerning client record retention, access by TDH to records pertaining to CSHCN program services, and confidentiality of client records and information shall remain in effect and binding upon provider if the remainder of this Agreement is terminated for any reason.

WITH THIS SIGNATURE, THE UNDERSIGNED AGREES TO THE ABOVE AND ATTESTS TO HAVE READ AND UNDERSTOOD AND AGREES TO UPHOLD THE CSHCN PROGRAM RULES:

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(Signature of Authorized Provider) (Date)

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(Typed Name) (Position/Title)

It is recommended that you retain a copy of this document for your records.

Revised 05/01